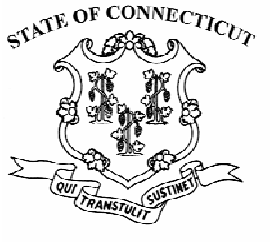

House Bill No. 6678

Public Act No. 15-118

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL AND OTHER CHANGES TO THE INSURANCE AND RELATED STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 38a-470 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Any insurer, hospital **[**or**]** service corporation, medical service corporation, health care center or employee welfare benefit plan **[**which**]** that furnished benefits or services under a health insurance policy or a self-insured employee welfare benefit plan to any person suffering an injury or illness covered by the Workers' Compensation Act has a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner less attorneys' fees approved by the district commissioner and reasonable costs related to the proceeding, to the extent of benefits paid or services provided for the effects of the injury or illness arising out of and in the course of employment as a result of a controverted claim, provided such plan, policy or contract provides for reduction, exclusion, or coordination of benefits of the policy or plan on account of workers' compensation benefits.

Sec. 2. Subsection (e) of section 38a-470 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(e) The insurance company providing workers' compensation coverage or the employer, if self-insured, shall reimburse the insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center or employee welfare benefit plan providing benefits or service directly, to the extent of any such lien. The receipt of such reimbursement by such insurer, hospital **[**or**]** service corporation, medical service corporation, health care center or employee welfare benefit plan shall fully discharge such lien.

Sec. 3. Subdivision (5) of section 38a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5) "Managed care organization" means an insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or other organization delivering, issuing for delivery, renewing, amending or continuing any individual or group health managed care plan in this state.

Sec. 4. Section 38a-489 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the

child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician on a form provided by the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

(b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital **[**or**]** service corporation, medical service **[**plan**]** corporation or health care center by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or health care center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer, corporation or health care center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

Sec. 5. Subdivision (5) of subsection (a) of section 38a-495a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5) "Issuer" means any insurance company, fraternal benefit society, hospital **[**or**]** service corporation, medical service corporation, health care center or any other entity **[**which**]** that delivers or issues for delivery, in this state, any Medicare supplement policies or certificates.

Sec. 6. Subdivision (3) of subsection (b) of section 38a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center or other

entity if the parties have entered into a contract providing for direct payment.

Sec. 7. Subsection (b) of section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) (1) Notwithstanding any other provision of this section, any insurance company, hospital **[**or**]** service corporation, medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for prescription contraceptive methods **[**which**]** that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to the individual an individual health insurance policy that excludes coverage for prescription contraceptive methods.

Sec. 8. Subsection (e) of section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(e) Notwithstanding any other provision of this section, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center **[**which**]** that is owned, operated or substantially controlled by a religious organization **[**which**]** that has religious or moral tenets **[**which**]** that conflict with the requirements of this section may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such

coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

Sec. 9. Section 38a-506 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Any insurer, hospital **[**or**]** service corporation, medical service corporation, health care center or fraternal benefit society, or any officer or agent thereof, delivering or issuing for delivery to any person in this state any policy in violation of any of the provisions of sections 38a-481 to 38a-488, inclusive, as amended by this act, shall be fined not more than ten thousand dollars for each offense, and the commissioner may revoke the license of any foreign or alien insurer, or any agent thereof, violating any of said provisions.

Sec. 10. Subsections (c) and (d) of section 38a-508 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child legally placed for adoption with the insured or subscriber who is an adoptive parent or a prospective adoptive parent, the policy or contract may require that notification of acceptance of such child and payment of the required premium or fees be furnished to the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center within thirty-one days after the acceptance of such child in order to continue coverage beyond such thirty-one-day period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such thirty-one-day period.

(d) Such policy (1) shall cover such child legally placed for adoption on the same basis as other dependents, and (2) may not contain any provision concerning preexisting conditions, insurability, eligibility or

health underwriting approval for a child legally placed for adoption, except that an insurer, hospital **[**or**]** service corporation, medical service corporation or health care center may require health underwriting for a child legally placed for adoption if a required premium or subscription fee and completed application materials are not provided to the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center before the expiration of the thirty-one-day period following the date the child was legally placed for adoption.

Sec. 11. Subsection (c) of section 38a-509 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) (1) Any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

Sec. 12. Subsection (a) of section 38a-513e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) In the event (1) an employer, as defined in section 31-58, terminates an employee for any reason other than layoff or relocation or closing of a covered establishment, as defined in section 31-51n, or

(2) an employee voluntarily terminates employment with an employer, such employer may elect not to pay the premium for such employee and any such employee's dependents under a group health insurance policy after the date of such employee's termination. In the event such employer makes such election, any insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or fraternal benefit society that issues such group health insurance policy shall credit such employer the amount of any premium paid by such employer with respect to such policy for such employee and such employee's dependents attributable to the period after the date of such employee's termination, provided the employer notifies the insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or fraternal benefit society that issued such policy and the terminated employee not later than seventy-two hours after the termination. Upon the issuance or renewal of such policy, such insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or fraternal benefit society shall provide such employer with relevant information related to such employer's election, including a notice that it is the employer's responsibility to remit to the terminated employee such employee's portion of the credited premium. Any such credit shall be applied to the employer's next month's premium. In the event of nonrenewal of such policy, the insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or fraternal benefit society shall refund such credit to the employer.

Sec. 13. Section 38a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, that

provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician on a form provided by the insurer, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

(b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital **[**or**]** service corporation, medical service **[**plan**]** corporation or health care center by the employee or member within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer, corporation or center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

Sec. 14. Subsection (b) of section 38a-523 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Any insurance company, hospital **[**or**]** service corporation, medical service corporation or health care center authorized to do the business of health insurance in this state shall offer to any individual, partnership, corporation or unincorporated association providing group health insurance coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 for its employees or members, a group hospital or medical service plan or contract

providing coverage for expenses incurred for comprehensive rehabilitation services under such terms and conditions as are agreed to by the policyholder and the insurer.

Sec. 15. Subdivision (3) of subsection (b) of section 38a-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center or other entity if the parties have entered into a contract providing for direct payment.

Sec. 16. Subsection (b) of section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) (1) Notwithstanding any other provision of this section, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to a religious employer a group health insurance policy that excludes coverage for prescription contraceptive methods **[**which**]** that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for prescription contraceptive methods.

Sec. 17. Subsection (e) of section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2015):

(e) Notwithstanding any other provision of this section, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center **[**which**]** that is owned, operated or substantially controlled by a religious organization **[**which**]** that has religious or moral tenets **[**which**]** that conflict with the requirements of this section may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured.

Sec. 18. Subsection (c) of section 38a-536 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) (1) Any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to a religious employer a group health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital **[**or**]** service corporation, medical service corporation **[**,**]** or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

Sec. 19. Section 38a-537 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Any individual, partnership, corporation **[**,**]** or unincorporated association providing group health insurance coverage for its

employees shall furnish each insured employee, upon cancellation or discontinuation of such health insurance, notice of the cancellation or discontinuation of such insurance. The notice shall be mailed or delivered to the insured employee not less than fifteen days next preceding the effective date of cancellation or discontinuation. Any individual or any such entity that fails to provide timely notice shall be fined not more than two thousand dollars for each violation. The Labor Commissioner shall have the authority to assess all such fines. This section shall apply to any such individual, partnership, corporation or unincorporated association that substitutes one policy providing group health insurance coverage for another such policy with no interruption in coverage.

(b) If any individual or any such entity fails to furnish notice pursuant to subsection (a) of this section, the individual or entity shall be liable for benefits to the same extent as the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center would have been liable if coverage had not been cancelled or discontinued.

(c) Any individual, partnership, corporation **[**,**]** or unincorporated association **[**which**]** that makes deductions from an employee's wages for group health insurance coverage and fails to procure such coverage shall be liable for benefits to the same extent as the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center would have been liable if coverage had been procured. If any corporation makes deductions from an employee's wages for group health insurance coverage and fails to procure such coverage, any officer of the corporation responsible for procuring such coverage for employees who wilfully failed to procure such coverage shall be personally liable for benefits to the same extent as the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center would have been liable if coverage had been procured,

provided **[**that**]** personal liability shall only be imposed against the officer in the event that an amount owed an employee due to the officer's failure cannot otherwise be collected from the corporation itself.

(d) Whenever an employer ceases doing business, any terminated employee whose group health insurance was discontinued on or before the date of termination of employment and who did not receive notice of such discontinuation pursuant to subsection (a) of this section shall be eligible for ninety days from the date of discontinuation to purchase as a conversion privilege an individual comprehensive health care plan for **[**himself**]** such employee and any dependents of such employee covered by the discontinued group health insurance plan from the former insurer, hospital **[**or**]** service corporation, medical service corporation, health care center or the Health Reinsurance Association, if any insurer is not issuing such coverage, with coverage retroactive to the date of discontinuation. The employee shall pay the premiums for the period of retroactive coverage. No retroactive coverage may be purchased for a period during which the employee is eligible for benefits under another group plan.

Sec. 20. Section 38a-548 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Any insurer, hospital **[**or**]** service corporation, medical service corporation, health care center or fraternal benefit society, or any officer or agent thereof, delivering or issuing for delivery to any person in this state any policy in violation of any of the provisions of sections 38a-512 to 38a-533, inclusive, as amended by this act, 38a-537 to 38a-542, inclusive, as amended by this act, and 38a-545, shall be fined not more than one thousand dollars for each offense, and the commissioner may revoke the license of any foreign or alien insurer, or any agent thereof, violating any of those provisions.

Sec. 21. Subsections (c) and (d) of section 38a-549 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child legally placed for adoption with the insured or subscriber who is an adoptive parent or a prospective adoptive parent, the policy may require that notification of acceptance of such child and payment of the required premium or fees be furnished to the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center within thirty-one days after the acceptance of such child in order to continue coverage beyond such thirty-one-day period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such thirty-one-day period.

(d) Such policy (1) shall cover such child legally placed for adoption on the same basis as other dependents, and (2) may not contain any provision concerning preexisting conditions, insurability, eligibility or health underwriting approval for a child legally placed for adoption, except that an insurer, hospital **[**or**]** service corporation, medical service corporation or health care center may require health underwriting for a child legally placed for adoption if a required premium or subscription fee and completed application materials are not provided to the insurer, hospital **[**or**]** service corporation, medical service corporation or health care center before the expiration of the thirty-one-day period following the date the child was legally placed for adoption.

Sec. 22. Subdivision (5) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5) "Insurer" means any insurance company, hospital **[**or**]** service

corporation, medical service corporation **[**,**]** or health care center, authorized to transact health insurance business in this state.

Sec. 23. Subsection (b) of section 38a-577 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) The provisions of sections 38a-577 to 38a-590, inclusive, shall not apply to a licensed insurance company, **[**a**]** licensed hospital service corporation or licensed medical service corporation or a health **[**maintenance organization**]** care center.

Sec. 24. Subdivision (2) of section 38a-1040 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(2) "Managed care organization" means an insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or other organization delivering, issuing for delivery, renewing or amending any individual or group health managed care plan in this state.

Sec. 25. Section 18-52a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Any person committed to the custody of the Commissioner of Correction who is confined in a correctional facility and requires hospitalization for medical care may be transferred by the department to any hospital having facilities for such care. If such person is covered by a health insurance policy, as defined in section 38a-469, and such policy provides coverage for such hospitalization or medical care, such person shall be liable to the hospital for all covered expenses, and (1) such person shall arrange to have the carrier pay the amount of covered expenses to the hospital, or (2) if such policy indemnifies the covered person for costs incurred, such person shall pay the hospital

for covered expenses. Each carrier shall provide benefits for covered expenses without regard to whether a person is committed to the custody of the Commissioner of Correction. If such person is not covered by a health insurance policy, the department shall reimburse the receiving hospital at a rate not to exceed that established under the provisions of section 17b-239. As used in this section, "carrier" means any insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center, fraternal benefit society or other entity which delivers, issues for delivery or renews a health insurance policy in this state.

Sec. 26. Subdivision (4) of subsection (a) of section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(4) "Managed care organization" means an insurer, health care center, hospital **[**or**]** service corporation, medical service corporation or other organization delivering, issuing for delivery, renewing or amending any individual or group health managed care plan in this state.

Sec. 27. Subsection (d) of section 8-265ss of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(d) A HERO loan shall: (1) Be a mortgage for up to thirty years in an amount determined by the authority; (2) provide an interest rate at an amount determined by the authority; (3) be serviced by the authority or its agents; and (4) have property taxes and insurance, including mortgage insurance, **[**homeowner's**]** homeowners insurance and, if applicable, flood insurance, included in the borrower's monthly payment amount.

Sec. 28. Subdivision (3) of subsection (a) of section 14-36m of the

general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(3) "Proof of residency" means a piece of mail or electronic mail that includes an applicant's name and address, indicates that such applicant resides in the state and is dated, unless otherwise indicated, not earlier than ninety days before an application for a motor vehicle operator's license, from any two of the following sources: (A) A bill from a bank or mortgage company, utility company, credit card company, doctor or hospital, (B) a bank statement or bank transaction receipt showing the bank's name and mailing address, (C) a preprinted pay stub, (D) a property or excise tax bill dated not earlier than twelve months before such application, (E) an annual benefits summary statement from the Social Security Administration or other pension or retirement plan dated not earlier than twelve months before such application, (F) a Medicaid or Medicare benefit statement, (G) a current **[**homeowner's**]** homeowners insurance or renter's insurance policy or motor vehicle insurance card or policy dated not earlier than twelve months before such application, (H) a residential mortgage or similar loan contract, lease or rental contract showing signatures from all parties needed to execute the agreement dated not earlier than twelve months before such application, (I) any postmarked mail, (J) a change of address confirmation from the United States Postal Service indicating an applicant's current and prior address, (K) a survey of an applicant's real property issued by a licensed surveyor, or (L) any official school records showing enrollment.

Sec. 29. Section 36a-719h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

No mortgage servicer shall:

(1) Directly or indirectly employ any scheme, device or artifice to defraud or mislead mortgagors or mortgagees or to defraud any

person;

(2) Engage in any unfair or deceptive practice toward any person or misrepresent or omit any material information in connection with the servicing of the residential mortgage loan, including, but not limited to, misrepresenting the amount, nature or terms of any fee or payment due or claimed to be due on a residential mortgage loan, the terms and conditions of the servicing agreement or the mortgagor's obligations under the residential mortgage loan;

(3) Obtain property by fraud or misrepresentation;

(4) Knowingly misapply or recklessly apply residential mortgage loan payments to the outstanding balance of a residential mortgage loan;

(5) Knowingly misapply or recklessly apply payments to escrow accounts;

(6) Place hazard, **[**homeowner's**]** homeowners or flood insurance on the mortgaged property when the mortgage servicer knows or has reason to know that the mortgagor has an effective policy for such insurance;

(7) Fail to comply with section 49-10a;

(8) Knowingly or recklessly provide inaccurate information to a credit bureau, thereby harming a mortgagor's creditworthiness;

(9) Fail to report both the favorable and unfavorable payment history of the mortgagor to a nationally recognized consumer credit bureau at least annually if the mortgage servicer regularly reports information to a credit bureau;

(10) Collect private mortgage insurance beyond the date for which private mortgage insurance is required;

(11) Fail to issue a release of mortgage in accordance with section 49-8;

(12) Fail to provide written notice to a mortgagor upon taking action to place hazard, **[**homeowner's**]** homeowners or flood insurance on the mortgaged property, including a clear and conspicuous statement of the procedures by which the mortgagor may demonstrate that he or she has the required insurance coverage and by which the mortgage servicer shall terminate the insurance coverage placed by it and refund or cancel any insurance premiums and related fees paid by or charged to the mortgagor;

(13) Place hazard, **[**homeowner's**]** homeowners or flood insurance on a mortgaged property, or require a mortgagor to obtain or maintain such insurance, in excess of the replacement cost of the improvements on the mortgaged property as established by the property insurer;

(14) Fail to provide to the mortgagor a refund of unearned premiums paid by a mortgagor or charged to the mortgagor for hazard, **[**homeowner's**]** homeowners or flood insurance placed by a mortgagee or the mortgage servicer if the mortgagor provides reasonable proof that the mortgagor has obtained coverage such that the forced placement insurance is no longer necessary and the property is insured. If the mortgagor provides reasonable proof that no lapse in coverage occurred such that the forced placement was not necessary, the mortgage servicer shall promptly refund the entire premium;

(15) Require any amount of funds to be remitted by means more costly to the mortgagor than a bank or certified check or attorney's check from an attorney's account to be paid by the mortgagor;

(16) Refuse to communicate with an authorized representative of the mortgagor who provides a written authorization signed by the

mortgagor, provided the mortgage servicer may adopt procedures reasonably related to verifying that the representative is in fact authorized to act on behalf of the mortgagor;

(17) Conduct any business covered by sections 36a-715 to 36a-719*l*, inclusive, without holding a valid license as required under said sections, or assist or aid and abet any person in the conduct of business without a valid license as required under this title;

(18) Negligently make any false statement or knowingly and wilfully make any omission of a material fact in connection with any information or reports filed with a governmental agency or the system or in connection with any investigation conducted by the Banking Commissioner or another governmental agency; or

(19) Collect, charge, attempt to collect or charge or use or propose any agreement purporting to collect or charge any fee prohibited by sections 36a-485 to 36a-498f, inclusive, 36a-534a and 36a-534b.

Sec. 30. Subdivision (1) of section 36a-760d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(1) With respect to nonprime home loans that are first mortgage loans for which the lender receives an application on or after April 1, 2010, the lender requires and collects a monthly escrow for the payment of real property taxes and **[**homeowner's**]** homeowners insurance. The provisions of this subdivision shall not apply to: (A) FHA loans; or (B) a nonprime home loan product which, in good faith, is generally designed and marketed to the public as a subordinate lien home equity loan product but is secured by a first mortgage loan;

Sec. 31. Subsection (b) of section 38a-12 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) On or before January **[**15, 2001, and**]** fifteenth annually, **[**thereafter,**]** the commissioner shall submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance a report, in accordance with the provisions of section 11-4a, detailing all the information the commissioner received during the past year pursuant to sections 29-311, 31-290d, 38a-356 and 53-445.

Sec. 32. Subdivision (1) of subsection (b) of section 38a-58g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) (1) Such alien insurer shall enter into a domestication agreement in writing with a domestic insurer that provides for the domestic insurer to succeed to all the business and assets and to assume all the liabilities of the United States branch. The agreement shall be effectuated, upon approval by the commissioner, by the filing of an instrument of transfer and assumption as set forth in subdivision (4) of this **[**section**]** subsection.

Sec. 33. Section 38a-69 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Except as otherwise provided in this title, **[**38a,**]** sections 38a-11, 38a-50, 38a-52, 38a-70 to 38a-76, inclusive, 38a-81 to 38a-83, inclusive, and 38a-153, and the regulations adopted to implement said sections apply to all insurers, including reinsurers, licensed to do business in this state.

Sec. 34. Subdivision (5) of subsection (g) of section 38a-156a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5) Policyholders of policies that confer the right to vote and are issued after the effective date by the reorganized insurer shall be

members of and have equity rights in the mutual holding company.

Sec. 35. Subdivision (2) of subsection (a) of section 38a-156e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(2) Provide an alternative practice to subdivision (1) of this subsection that protects the contractual rights of individual policyholders of the reorganizing insurer with policies in force on the effective date, if the commissioner determines that such alternative is substantially as protective of the interests of individual participating policyholders as the establishment of a closed block pursuant to subdivision (1) of this **[**section**]** subsection.

Sec. 36. Section 38a-261 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

A purchasing group **[**which**]** that intends to do business in this state shall furnish notice to the Insurance Commissioner **[**which**]** that shall: (1) Identify the state in which the group is domiciled; (2) specify the lines and classifications of liability insurance **[**which**]** that the purchasing group intends to purchase; (3) identify the insurance company from which the group intends to purchase its insurance and the domicile of such company; (4) identify the principal place of business of the group; (5) provide such other information as may be required by the Insurance Commissioner to verify that the purchasing group satisfies the definitional requirements of subdivision (10) of section 38a-250; (6) register with and designate the Insurance Commissioner as its agent solely for the purpose of receiving service of legal documents or process, in accordance with Section 4 of the Liability Risk Retention Act of 1986; (7) identify all other states in which the group intends to do business; and (8) specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this

state. A purchasing group shall **[**, within ten days,**]** notify the commissioner of any **[**changes**]** change in any of the items set forth in this section not later than ten days after any such change.

Sec. 37. Subsection (d) of section 38a-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(d) Any non-English-language policy shall be deemed to be in compliance with subsection (a) of this section if the insurer certifies that such policy is translated from an English-language policy **[**which**]** that complies with said subsection (a).

Sec. 38. Subdivision (4) of subsection (a) of section 38a-298 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(4) The sum of the figures computed under subdivisions (2) and (3) of this subsection subtracted from 206.835 equals the Flesch reading ease score for the policy form.

Sec. 39. Section 38a-307a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

From July 1, 2004, until the expiration of the Terrorism Insurance Program established in the federal Terrorism Risk Insurance Act of 2002, P.L. 107-297, as amended and reauthorized from time to time, (1) for any master policy that is required to be purchased by a condominium association pursuant to section 47-83 or by a unit owners' association pursuant to section 47-255, the standard form of fire insurance policy set forth in section 38a-307 shall not exclude coverage for loss by fire or other perils insured against in the policy caused, directly or indirectly, by terrorism, as defined by the Insurance Commissioner; and (2) for any other commercial risk insurance policy, the standard form of fire insurance policy set forth in section 38a-307

may provide that the company shall not be liable for loss by fire or other perils insured against in the policy caused, directly or indirectly, by terrorism, as defined by the Insurance Commissioner, provided the premiums charged for such policy shall reflect any savings projected from the exclusion of such perils.

Sec. 40. Subsection (f) of section 38a-322a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(f) The commissioner may conduct an investigation, pursuant to section 38a-16, of any person the commissioner reasonably believes has **[**been**]** violated or is engaged in a violation of any provision of this section.

Sec. 41. Section 38a-330 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Each property and casualty insurer **[**which**]** that, at the time of policy renewal, transfers any policy to an affiliate as a result of a merger or acquisition of control, shall provide notice to policyholders at least sixty days prior to the effective date of transfer. Such transfer shall not require a nonrenewal or cancellation of the policy.

Sec. 42. Section 38a-338 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Policies affording bodily injury liability, property damage liability and uninsured motorist coverages to which the provisions of sections 38a-334 to 38a-336a, inclusive, **[**38a-338**]** and 38a-340 apply shall be deemed to provide insurance under such coverages in accordance with **[**such**]** regulations adopted pursuant to section 38a-334. Policies affording medical payments coverage to which the provisions of said sections apply shall be deemed to provide insurance under such coverage in accordance with such regulations.

Sec. 43. Subsection (c) of section 38a-472 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) No insurer, health care center or issuer of any service plan contract for hospital or medical expense coverage delivered, issued for delivery or renewed in this state shall impose requirements on the Department of Social Services **[**which**]** that have the effect of denying or limiting benefits **[**which**]** that have been assigned pursuant to this section. The assignment of benefits shall be in accordance with the provisions of this section. **[**38a-472.**]**

Sec. 44. Section 38a-472a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

No contract between a managed care company, other organization or insurer authorized to do business in this state and a medical provider practicing in this state for the provision of services may require that the medical provider indemnify the managed care company, other organization or insurer for any expenses and liabilities including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against a managed care company, other organization or insurer on the basis of its determination of medical necessity or appropriateness of health care services if the information provided by **[**said**]** such medical provider used in making the determination was accurate and appropriate at the time it was given. As used in this section and section 38a-472b, "medical provider" means any person licensed pursuant to chapters 370 to 373, inclusive, or chapter 375, 379, 380 or 383.

Sec. 45. Subdivision (1) of subsection (a) of section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July first of each year, all data required by the National Committee for Quality Assurance **[**(NCQA)**]** for its Health Plan Employer Data and Information Set. **[**(HEDIS).**]** If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision;

Sec. 46. Subdivision (4) of subsection (a) of section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this **[**section**]** subsection, including any change in a plan's rates over the prior three years, its state medical loss ratio and its federal medical loss ratio, as both terms are defined in section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and specialty care provider, the percentage of primary and specialty care providers who are board certified, and how the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner;

Sec. 47. Subdivision (14) of subsection (b) of section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(14) The status of the National Committee for Quality Assurance **[**(NCQA)**]** accreditation;

Sec. 48. Subsection (c) of section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay. Such data shall be collected in a manner consistent with the National Committee for Quality Assurance Health Plan Employer Data and Information Set **[**(HEDIS)**]** measures.

Sec. 49. Subsection (c) of section 38a-478r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) For the purposes of this section, in accordance with the National Committee for Quality Assurance, an emergency medical condition is a condition such that a prudent **[**lay-person**]** layperson, acting reasonably, would have believed that emergency medical treatment is needed.

Sec. 50. Subsections (a) to (c), inclusive, of section 38a-481 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. Rate

filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, premium rates and loss ratios from the inception of the policy. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer **[**which**]** that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until it has been **[**filed and**]** approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age,

gender, previous claims history or the medical condition of any person covered by such policy or certificate.

Sec. 51. Subsections (a) and (b) of section 38a-513 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) No group health insurance policy, as defined by the commissioner, or certificate shall be **[**issued or**]** delivered or issued for delivery in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. If the commissioner issues an order disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

Sec. 52. Section 38a-503c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or

continuing any individual health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469.

(b) Each individual health insurance carrier that offers maternity benefits shall provide coverage of a minimum of forty-eight hours of inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of ninety-six hours of inpatient care for a mother and her newborn infant following a caesarean delivery. The time periods shall commence at the time of delivery.

(c) Any decision to shorten the length of inpatient stay to less than that provided under subsection (b) of this section shall be made by the attending health care providers after conferring with the mother.

(d) If a mother and newborn are discharged pursuant to subsection (c) of this section, prior to the inpatient length of stay provided under subsection (b) of this section, coverage shall be provided for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Such follow-up services shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care.

[(e) Each individual health insurance carrier shall provide notice to policyholders regarding the coverage required under this section. The notice shall be in writing and shall be transmitted at the earliest of either the next mailing to the policyholder, the yearly summary of

benefits sent to the policyholder or January 1, 1997.**]**

Sec. 53. Section 38a-530c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469.

(b) Each group insurance carrier that offers maternity benefits shall provide coverage of a minimum of forty-eight hours of inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of ninety-six hours of inpatient care for a mother and her newborn infant following a caesarean delivery. The time periods shall commence at the time of delivery.

(c) Any decision to shorten the length of inpatient stay to less than that provided under subsection (b) of this section shall be made by the attending health care providers after conferring with the mother.

(d) If a mother and newborn are discharged pursuant to subsection (c) of this section, prior to the inpatient length of stay provided under subsection (b) of this section, coverage shall be provided for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Such follow-up services shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional

organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care.

[(e) Each group insurance carrier shall provide notice to policyholders regarding the coverage required under this section. The notice shall be in writing and shall be transmitted at the earliest of either the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder or January 1, 1997.**]**

Sec. 54. Subparagraph (H) of subdivision (1) of subsection (e) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(H) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil **[**suit**]** action in a court of competent jurisdiction. Such statement shall include the contact information for said offices; and

Sec. 55. Section 38a-663 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The following words and phrases, as used in sections 38a-663 to 38a-696, inclusive, as amended by this act, shall have the following meanings unless the context otherwise requires:

[(a)**]** (1) "Rating organization" means an individual, partnership, corporation, unincorporated association, other than an admitted insurer, whether located within or outside this state, who or **[**which**]** that has as a primary object or purpose the making of rates, rating plans or rating systems. Two or more admitted insurers **[**which**]** that act in concert for the purpose of making rates, rating plans or rating systems, and **[**which**]** that do not operate within the specific

authorizations contained in sections 38a-667, 38a-669, 38a-670 and 38a-672 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

[(b)**]** (2) "Advisory organization" means every group, association or other organization of insurers, whether located within or outside this state, **[**which**]** that assists insurers or rating organizations in rate-making by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, provided the term shall not include actuarial, legal or other consultants.

[(c)**]** (3) "Member" means an insurer **[**who**]** that participates in or is entitled to participate in the management of a rating, advisory or other organization.

[(d)**]** (4) "Subscriber" means an insurer **[**which**]** that is furnished at its request **[**(1)**]** (A) with rates and rating manuals by a rating organization of which it is not a member, or **[**(2)**]** (B) with advisory services by an advisory organization of which it is not a member.

[(e)**]** (5) "Wilful" and "wilfully" in relation to an act or omission **[**which**]** that constitutes a violation of sections 38a-663 to 38a-681, inclusive, as amended by this act, means with actual knowledge or belief that such act or omission constitutes such violation and with specific intent to commit such violation.

[(f)**]** (6) "Market" means the interaction between buyers and sellers consisting of a product market component and a geographic market component, as determined by the commissioner in accordance with the provisions of subsection (b) of section 38a-687.

[(g)**]** (7) "Noncompetitive market" means a residual market or a market for which there is a ruling in effect pursuant to section 38a-687, that a reasonable degree of competition does not exist.

[(h)**]** (8) "Competitive market" means a market **[**which**]** that has not been found to be noncompetitive pursuant to section 38a-687.

[(i)**]** (9) "Personal risk insurance" means homeowners, tenants, private passenger nonfleet automobile, mobile manufactured home and other property and casualty insurance for personal, family or household needs except workers' compensation insurance.

[(j)**]** (10) "Commercial risk insurance" means insurance within the scope of sections 38a-663 to 38a-696, inclusive, **[**which**]** as amended by this act, that is not personal risk insurance.

[(k)**]** (11) "Supplementary rate information" includes any manual or plan of rates, classification, rating schedule, minimum premium, rating rule, and any other similar information needed to determine the applicable rate in effect or to be in effect.

[(l)**]** (12) "Supporting information" means **[**(1)**]** (A) the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, **[**(2)**]** (B) the interpretation of any statistical data relied upon by the filer, and **[**(3)**]** (C) descriptions of methods used in making the rates, and other similar information required to be filed by the commissioner.

[(m)**]** (13) "Residual market" means an arrangement for the provision of insurance in accordance with the provisions of section 38a-328, 38a-329 or 38a-670.

Sec. 56. Section 38a-740 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The commissioner may by regulation adopted in accordance with the provisions of chapter 54: (1) Establish such proper standards as **[**he may deem**]** the commissioner deems necessary to guide surplus lines brokers procuring any such policy of insurance, as is permitted under

subsection (a) of section 38a-794, from any such unauthorized insurer; (2) require any unauthorized insurer from which any surplus lines broker has procured or intends to procure any policy of insurance, as is permitted under subsection (a) of section 38a-794, to file with **[**him**]** the commissioner such evidence and in such form as **[**he may prescribe so as**]** the commissioner prescribes to enable **[**him**]** the commissioner to establish the financial stability, qualifications and general suitability of such unauthorized insurer to issue any policy of insurance through any surplus lines broker, under section 38a-794; and (3) establish such reasonable filing fees as may be necessary to defray the cost **[**to him**]** of examining evidence filed with **[**him**]** the commissioner by an unauthorized insurer either voluntarily or pursuant to the provisions of this section.

Sec. 57. Section 38a-742 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The licensee shall keep a complete and separate record of all policies procured from unauthorized insurers under such license. Such records shall be open to the examination of the commissioner at all reasonable times and shall show: (1) The exact amount of each kind of insurance permitted under sections 38a-741 to 38a-744, inclusive, and 38a-794 that has been procured for each insured; (2) the gross premiums charged by the insurers for each kind of insurance permitted under section 38a-794; (3) the amount of each kind of premiums of insurance permitted by section 38a-794 **[**which**]** that were returned to each insured; (4) the name of the insurer or insurers **[**which**]** that issued each of such policies; (5) the effective dates of such policies; and (6) the terms for which they were issued.

Sec. 58. Subsection (b) of section 38a-940 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(b) Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation. To the extent the insured files a claim, it shall be deemed sufficient to cover all related third party claims. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 38a-924, whichever is later, the **[**insurer**]** insured shall be deemed an unexcused late filer.

Sec. 59. Subsection (a) of section 38a-1051 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Whereas the General Assembly finds that: (1) Equal enjoyment of the highest attainable standard of health is a human right and a priority of the state, (2) research and experience demonstrate that inhabitants of the state experience barriers to the equal enjoyment of good health based on race, ethnicity, gender, national origin and linguistic ability, and (3) addressing such barriers, and others that may arise in the future, requires: The collection, analysis and reporting of information, the identification of causes, and the development and implementation of policy solutions that address health disparities while improving the health of the public as a whole therefore, there is established a Commission on Health Equity with the mission of eliminating disparities in health status based on race, ethnicity, gender and linguistic ability, and improving the quality of health for all of the state's residents. Such commission shall consist of the following commissioners, or their designees, and public members: (A) The Commissioners of Public Health, Mental Health and Addiction Services, Developmental Services, Social Services, Correction, Children and Families, and Education; (B) the dean of The University of Connecticut Health Center, or his or her designee; (C) the director of The University of Connecticut Health Center and Center for Public Health and Health Policy, or their designees; (D) the dean of the Yale

University Medical School, or his or her designee; (E) the dean of [Public Health and the School of Epidemiology at Yale University] the Yale School of Public Health, or his or her designee; (F) one member appointed by the president pro tempore of the Senate, who shall be a member of an affiliate of the National Urban League; (G) one member appointed by the speaker of the House of Representatives, who shall be a member of the National Association for the Advancement of Colored People; (H) one member appointed by the majority leader of the House of Representatives, who shall be a member of the Black and Puerto Rican Caucus of the General Assembly; (I) one member appointed by the majority leader of the Senate with the advice of the Native American Heritage Advisory Council or the chairperson of the Indian Affairs Council, who shall be a representative of the Native American community; (J) one member appointed by the minority leader of the Senate, who shall be a representative of an advocacy group for Hispanics; (K) one member appointed by the minority leader of the House of Representatives, who shall be a representative of the state-wide Multicultural Health Network; (L) the chairperson of the African-American Affairs Commission, or his or her designee; (M) the chairperson of the Latino and Puerto Rican Affairs Commission, or his or her designee; (N) the chairperson of the Permanent Commission on the Status of Women, or his or her designee; (O) the chairperson of the Asian Pacific American Affairs Commission, or his or her designee; (P) the director of the Hispanic Health Council, or his or her designee; (Q) [the chairperson of the Office of] the Healthcare Advocate, or his or her designee; and (R) eight members of the public, representing communities facing disparities in health status based on race, ethnicity, gender and linguistic ability, who shall be appointed as follows: Two by the president pro tempore of the Senate, two by the speaker of the House of Representatives, two by the minority leader of the Senate, and two by the minority leader of the House of Representatives. Vacancies on the council shall be filled by the appointing authority.

Sec. 60. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

For purposes of sections 38a-1080 to **[**38a-1091**]** 38a-1092, inclusive, as amended by this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081, as amended by this act;

(4) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

(5) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(iii) Other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan

maintained by the same plan sponsor;

(6) "Health care services" has the same meaning as provided in section 38a-478, as amended by this act;

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

(8) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(9) "Person" has the same meaning as provided in section 38a-1;

(10) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 38a-1086;

(11) "Qualified employer" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(12) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Affordable Care Act and section 38a-1086;

(13) "Qualified individual" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services;

(15) "Small employer" has the same meaning as provided in section

38a-564, as amended by this act.

Sec. 61. Subdivisions (3) and (4) of subsection (c) of section 38a-1081 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(3) Appointed board members may not designate a representative to perform in their absence their respective duties under sections 38a-1080 to **[**38a-1091**]** 38a-1092, inclusive, as amended by this act. The Governor shall select a chairperson from among the board members and the board members shall annually elect a vice-chairperson. Meetings of the board of directors shall be held at such times as shall be specified in the bylaws adopted by the board and at such other time or times as the chairperson deems necessary. Any board member who fails to attend more than fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the board.

(4) Six board members shall constitute a quorum for the transaction of any business or the exercise of any power of the exchange. For the transaction of any business or the exercise of any power of the exchange, the exchange may act by a majority of the board members present at any meeting at which a quorum is in attendance. No vacancy in the membership of the board of directors shall impair the right of such board members to exercise all the rights and perform all the duties of the board. Except as otherwise provided in sections 38a-1080 to 38a-1092, inclusive, as amended by this act, any action taken by the board under the provisions of sections 38a-1080 to **[**38a-1091**]** 38a-1092, inclusive, as amended by this act, may be authorized by resolution approved by a majority of the board members present at any regular or special meeting, which resolution shall take effect immediately unless otherwise provided in the resolution.

Sec. 62. Subparagraph (B) of subdivision (3) of subsection (b) of section 38a-1091 of the general statutes is repealed and the following is

substituted in lieu thereof (*Effective October 1, 2015*):

(B) The chief executive officer <u>of the exchange</u> may provide the name of any reporting entity on which such penalty has been imposed to the commissioner. After consultation with said officer, the commissioner may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any penalty imposed pursuant to subparagraph (A) of this subdivision.

Sec. 63. Section 38a-1092 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Not later than March 31, 2014, and quarterly thereafter, the **[**Connecticut Health Insurance Exchange**]** <u>exchange</u> board of directors **[**, established pursuant to section 38a-1081,**]** shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and insurance concerning health care services provided through the exchange. Such reports shall include: (1) The number of persons in households with incomes from one hundred thirty-three per cent up to one hundred fifty per cent of the federal poverty level who were enrolled in a qualified health plan at any time on or after January 1, 2014; (2) the number of persons in households with incomes from one hundred fifty per cent up to and including two hundred per cent of the federal poverty level who were enrolled in a qualified health plan at any time on and after January 1, 2014; (3) the number of persons in households with incomes from one hundred thirty-three per cent up to and including two hundred per cent of the federal poverty level who have been continuously enrolled in a qualified health plan during the current calendar year; (4) the number of persons in households with incomes from one hundred thirty-three per cent up to and including two hundred per cent of the federal poverty level who were enrolled in a qualified health plan and who subsequently became eligible to receive benefits under the Medicaid program or whose household

income increased to more than two hundred per cent of the federal poverty level; (5) the number of persons in households with incomes from one hundred thirty-three per cent up to and including two hundred per cent of the federal poverty level who experienced a gap in health care coverage; (6) the cost to the state of providing health care services to persons identified in subdivision (5) of this subsection and the cost to such persons to access health care coverage through the exchange; (7) the cost of the second-lowest-priced silver premium plan in the exchange; and (8) any other information that said board believes would be necessary to allow said committees to evaluate the cost and benefits of a basic health plan.

(b) The **[**Connecticut Health Insurance Exchange**]** exchange board of directors shall include in the first quarterly report submitted each year to said committees in accordance with subsection (a) of this section, the number of persons in households with incomes from one hundred thirty-three up to and including two hundred per cent of the federal poverty level who were enrolled in a qualified health plan at the end of the previous calendar year.

Sec. 64. Section 52-549n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

In accordance with the provisions of section 51-14, the judges of the Superior Court may make such rules as they deem necessary to provide a procedure in accordance with which the court, in its discretion, may refer to a fact-finder for proceedings authorized pursuant to this chapter, any contract action pending in the Superior Court, except claims under insurance contracts for uninsured and **[**or**]** underinsured motorist coverage, in which only money damages are claimed and which is based upon an express or implied promise to pay a definite sum, and in which the amount, legal interest or property in controversy is less than fifty thousand dollars exclusive of interest and costs. Such cases may be referred to a fact-finder only after the

certificate of closed pleadings has been filed, no claim for a jury trial has been filed at the time of reference, and the time prescribed in section 52-215 for filing a jury trial claim within thirty days of the return day or within ten days after the issue of fact has been joined has expired.

Sec. 65. Subsection (a) of section 38a-199 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) A hospital service corporation is defined as a non-profit-sharing corporation without capital stock organized under the laws of the state for the purpose of establishing, maintaining and operating a plan whereby comprehensive health care, which shall include inpatient and outpatient hospital care and home care, provided and billed by an approved general, special or chronic disease hospital, an approved clinic or an approved chronic and convalescent nursing home, and services incidental thereto, may be provided, at the expense of said corporation, to subscribers to such plan under a contract entitling such subscribers to the benefits provided therein. When so determined by any such corporation comprehensive health care shall also include appliances, drugs, medicines, supplies and all other health goods and services, including the services of physicians, doctors of dentistry and other licensed practitioners of the healing arts. Each such corporation shall be governed by sections 38a-199 to 38a-209, inclusive, and shall, except as **[**specifically designated herein**]** otherwise provided in this title, be exempt from the provisions of the general statutes relating to insurance. The provisions of sections 38a-815 to 38a-819, inclusive, except subdivision (9) of section 38a-816, shall be applicable to such corporation. Such hospitals, clinics and chronic and convalescent nursing homes as shall be contained in a list of approved institutions maintained by the Department of Public Health shall be deemed approved for the purposes of sections 38a-199 to 38a-209, inclusive.

Sec. 66. Subsection (a) of section 38a-214 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) A nonprofit medical service corporation is defined as a non-profit-sharing corporation without capital stock organized under the laws of the state for the purpose of establishing, maintaining and operating a plan whereby comprehensive health care, which shall include inpatient and outpatient hospital care and home care, provided and billed by an approved general, special or chronic disease hospital, an approved clinic or an approved chronic and convalescent nursing home and services incidental thereto may be provided, at the expense of said corporation, to subscribers to such plan under a contract entitling such subscribers to the benefits provided therein. When so determined by any such corporation, comprehensive health care shall also include appliances, drugs, medicines, supplies and all other health goods and services, including the services of physicians, doctors of dentistry and other licensed practitioners of the healing arts. Any such corporation which provides coverage for the services of physicians shall also provide coverage for the services of chiropractors licensed under chapter 372 and naturopaths licensed under chapter 373. Each such corporation shall, except as **[**specifically designated herein**]** otherwise provided in this title, be exempt from the provisions of the general statutes relating to insurance. The provisions of sections 38a-815 to 38a-819, inclusive, except subdivision (9) of section 38a-816, shall be applicable to such corporation. Such hospitals, clinics and chronic and convalescent nursing homes as shall be contained in a list of approved institutions maintained by the Department of Public Health shall be deemed approved for the purposes of sections 38a-214 to 38a-225, inclusive.

Sec. 67. Subsection (b) of section 38a-480 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2015):

(b) **[**The**]** Except as otherwise provided in this title, the provisions of sections 38a-481 to 38a-488, inclusive, as amended by this act, 38a-492, 38a-502 and 38a-505 shall not apply to any subscriber contract issued by a health care center.

Sec. 68. Section 38a-512 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

Any policy providing major medical expense coverage **[**which**]** that is written to complement underlying hospital, medical and surgical expense coverage **[**, unless otherwise specifically provided,**]** shall not be required, unless otherwise specifically provided, to include the benefits required in the underlying hospital, medical and surgical expense coverage. **[**The**]** Except as otherwise provided in this title, the provisions of sections 38a-513, as amended by this act, 38a-529, 38a-532, 38a-545 and 38a-547 shall not apply to any subscriber contract issued by a health care center.

Sec. 69. Section 38a-336 of the general statutes, as amended by section 1 of public act 14-20, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) (1) (A) Each automobile liability insurance policy shall provide insurance, herein called uninsured and underinsured motorist coverage, in accordance with the regulations adopted pursuant to section 38a-334, with limits for bodily injury or death not less than those specified in subsection (a) of section 14-112, for the protection of persons insured thereunder who are legally entitled to recover damages because of bodily injury, including death resulting therefrom, from owners or operators of uninsured motor vehicles and underinsured motor vehicles and insured motor vehicles, the insurer of which becomes insolvent prior to payment of such damages. **[**,

because of bodily injury, including death resulting therefrom.**]**

(B) Each insurer licensed to write automobile liability insurance in this state shall provide uninsured and underinsured **[**motorists**]** motorist coverage with limits requested by any named insured upon payment of the appropriate premium, provided each such insurer shall offer such coverage with limits that are twice the limits of the bodily injury coverage of the policy issued to the named insured. The insured's selection of uninsured and underinsured motorist coverage shall apply to all subsequent renewals of coverage and to all policies or endorsements **[**which**]** that extend, change, supersede or replace an existing policy issued to the named insured, unless changed in writing by any named insured.

(C) No insurer shall be required to provide uninsured and underinsured motorist coverage to **[**(A)**]** (i) a named insured or relatives residing in **[**his**]** the named insured's household when occupying, or struck as a pedestrian by, an uninsured or underinsured motor vehicle or a motorcycle that is owned by the named insured, except as provided in subparagraph (D) of this subdivision, or **[**(B)**]** (ii) any insured occupying an uninsured or underinsured motor vehicle or motorcycle that is owned by such insured.

(D) For each automobile liability insurance policy issued or renewed on or after October 1, 2014, an insurer shall not deny uninsured motorist coverage to a named insured or any relative residing in the named insured's household solely on the basis that the named insured or such relative was struck as a pedestrian by a motor vehicle or motorcycle, during the theft of such motor vehicle or motorcycle, that is owned by the named insured and listed as a covered motor vehicle on the named insured's policy.

(2) Notwithstanding any provision of this section, each automobile liability insurance policy issued or renewed on and after January 1,

1994, shall provide uninsured and underinsured motorist coverage with limits for bodily injury and death equal to those purchased to protect against loss resulting from the liability imposed by law unless any named insured requests in writing a lesser amount, but not less than the limits specified in subsection (a) of section 14-112. Such written request shall apply to all subsequent renewals of coverage and to all policies or endorsements that extend, change, supersede or replace an existing policy issued to the named insured, unless changed in writing by any named insured. No such written request for a lesser amount shall be effective unless any named insured has signed an informed consent form that shall contain: (A) An explanation of uninsured and underinsured motorist insurance approved by the commissioner; (B) a list of uninsured and underinsured motorist coverage options available from the insurer; and (C) the premium cost for each of the coverage options available from the insurer. Such informed consent form shall contain a heading in twelve-point type and shall state: "WHEN YOU SIGN THIS FORM, YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE AGENT OR ANOTHER QUALIFIED ADVISER."

(b) An insurance company shall be obligated to make payment to its insured up to the limits of the policy's uninsured and underinsured motorist coverage after the limits of liability under all bodily injury liability bonds or insurance policies applicable at the time of the accident have been exhausted by payment of judgments or settlements, but in no event shall the total amount of recovery from all policies, including any amount recovered under the insured's uninsured and underinsured motorist coverage, exceed the limits of the insured's uninsured and underinsured motorist coverage. In no event shall there

be any reduction of uninsured or underinsured motorist coverage limits or benefits payable (1) for amounts received by the insured for Social Security disability benefits paid or payable pursuant to the Social Security Act, 42 USC Section 301, et seq., or (2) with respect to an automobile liability insurance policy issued or renewed on or after October 1, 2015, (A) for amounts paid by or on behalf of any tortfeasor for bodily injury to anyone other than individuals insured under the policy against which the claim is made, or (B) for amounts paid by or on behalf of any tortfeasor for property damage. The limitation on the total amount of recovery from all policies shall not apply to underinsured motorist conversion coverage purchased pursuant to section 38a-336a.

(c) Each automobile liability insurance policy issued on or after October 1, 1971, **[**which**]** that contains a provision for binding arbitration shall include a provision for final determination of insurance coverage in such arbitration proceeding. With respect to any claim submitted to arbitration on or after October 1, 1983, the arbitration proceeding shall be conducted by a single arbitrator if the amount in demand is forty thousand dollars or less or by a panel of three arbitrators if the amount in demand is more than forty thousand dollars.

(d) Regardless of the number of policies issued, vehicles or premiums shown on a policy, premiums paid, persons covered, vehicles involved in an accident, or claims made, in no event shall the limit of liability for uninsured and underinsured motorist coverage applicable to two or more motor vehicles covered under the same or separate policies be added together to determine the limit of liability for such coverage available to an injured person or persons for any one accident. If a person insured for uninsured and underinsured motorist coverage is an occupant of a nonowned vehicle covered by a policy also providing uninsured and underinsured motorist coverage, the

coverage of the occupied vehicle shall be primary and any coverage for which such person is a named insured shall be secondary. All other applicable policies shall be excess. The total amount of uninsured and underinsured motorist coverage recoverable is limited to the highest amount recoverable under the primary policy, the secondary policy or any one of the excess policies. The amount paid under the excess policies shall be apportioned in accordance with the proportion that the limits of each excess policy bear to the total limits of the excess policies. If any person insured for uninsured and underinsured motorist coverage is an occupant of an owned vehicle, the uninsured and underinsured motorist coverage afforded by the policy covering the vehicle occupied at the time of the accident shall be the only uninsured and underinsured motorist coverage available.

(e) For the purposes of this section, an "underinsured motor vehicle" means a motor vehicle with respect to which the sum of the limits of liability under all bodily injury liability bonds and insurance policies applicable at the time of the accident is less than the applicable limits of liability under the uninsured motorist portion of the policy against which claim is made under subsection (b) of this section.

(f) Notwithstanding subsection (a) of section 31-284, an employee of a named insured injured while occupying a covered motor vehicle in the course of employment shall be covered by such insured's otherwise applicable uninsured and underinsured motorist coverage.

(g) (1) No insurance company doing business in this state may limit the time within which any suit may be brought against it or any demand for arbitration on a claim may be made on the uninsured or underinsured motorist provisions of an automobile liability insurance policy to a period of less than three years from the date of accident, provided, in the case of an underinsured motorist claim the insured may toll any applicable limitation period (A) by notifying such insurer prior to the expiration of the applicable limitation period, in writing, of

any claim which the insured may have for underinsured motorist benefits and (B) by commencing suit or demanding arbitration under the terms of the policy not more than one hundred eighty days from the date of exhaustion of the limits of liability under all automobile bodily injury liability bonds or automobile insurance policies applicable at the time of the accident by settlements or final judgments after any appeals.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, in the case of an uninsured motorist claim, if the motor vehicle of a tortfeasor is an uninsured motor vehicle because the automobile liability insurance company of such tortfeasor becomes insolvent or denies coverage, no insurance company doing business in this state may limit the time within which any suit may be brought against it or any demand for arbitration on a claim may be made on the uninsured motorist provisions of an automobile liability insurance policy to a period of less than one year from the date of receipt by the insured of written notice of such insolvency of, or denial of coverage by, such automobile liability insurance company.

Sec. 70. Subsection (c) of section 38a-354a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(c) **[**(1)**]** If there is any communication between a glass claims representative for an insurance company doing business in this state or a third-party claims administrator for such company and an insured regarding automotive glass work or automobile glass products, in the initial contact with the insured, such representative or claims administrator shall state or disclose to the insured a statement substantially similar to the following: "You have the right to choose a licensed glass shop where the damage to your motor vehicle will be repaired. If you have a preference, please let us know.".

[(2) No glass claims representative for an insurance company doing business in this state or a third-party claims administrator for such company shall provide an insured with the name of, schedule an appointment for an insured with or direct an insured to, a licensed glass shop that is owned by (A) such company, (B) such claims administrator, or (C) the same parent company as such insurance company or claims administrator, unless such representative or claims administrator provides the insured with the name of at least one additional licensed glass shop in the area where the automotive glass work is to be performed.**]**

Sec. 71. Sections 38a-483b and 38a-513a of the general statutes are repealed. (*Effective October 1, 2015*)

Approved June 23, 2015